LTC Residents Protection
OCT 14 2009
Director's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	07/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

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F 000	INITIAL COMMENTS Revised report following IDR held on 9/30/09. The following changes were made: F225 was deleted. F 248 change in scope and severity from a G to a D, some text changes made. F323 no change in scope and severity, some text changes made. An unannounced QIS annual survey was conducted at this facility from July 20, 2009 through July 25, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 98. The survey sample totaled 107 residents, which included 40 census residents, 30 admission residents and 37 stage 2 residents.	F 000		
F 174 SS=E	483.10(k) TELEPHONE The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and review of facility documents, it was determined that the facility failed to provide residents phone access in a private area where calls can be made without being overheard. Findings include: 1. During interviews on 7/21/09 at 1:35 PM and 7/23/09 at 12:30 PM, resident, R91, stated that he does not have privacy when using the telephone. He stated that he has to use the telephone at the	F 174	F174 1. Administrator reinforced to R15 the availability and location of 24 hour private use cordless phone to residents in Resident Council August 2009. The cordless phone is located in the business office during regular business hours and with the facility nursing supervisor during evening and night hours. Administrator delegated the Social Service Director to speak with R91 regarding the above information. 2. All residents have the potential to be affected by this deficient practice.	9/4/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura L Dittman RN, MS | TITLE: NHA | (X6) DATE: 10/14/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 174	Continued From page 1 desk (nurses' station) and that a phone conversation can be overheard. 2. During an interview on 7/23/09 at 4:00 PM, resident, E29, stated that "... bought her a phone because there was no phone privacy... that she had to use the phone at the nurses' desk which is not private or go to the front office... they (facility) have a portable phone but everyone is sitting around there and so there is no privacy there either..." and that's why... had to buy her own phone. 3. During an interview on 7/24/09 at 5:20 PM, the Resident Council President, R15 stated that as far as she knows, residents who don't have there own phone go to the desk and that it is not private. On 7/23/09 at 3:15 PM, the Director of Nursing, E2, and the Administrator, E1, stated that residents can purchase telephone service for $16.00/month... or they could use any of the offices... or the nurses' desk. and that there is a "portable phone" in the building that they could use..... They added that they believed that... (E9) from admissions even goes over that with the families during the admissions process. Interview with E9 in the Admissions Office stated that there are no longer free phones... residents can bring their own phones and pay $16.00/month or if they can't afford one, there is a portable phone in the front office. A copy of the phone Admission Agreement entitled, "Regency Healthcare Telephone Service" was provided. Review of this phone admission agreement stated, "Each resident must provide their own	F 174	3. Administrator addressed Resident Council in August 2009 and September 2009 regarding location and availability of 24 hour cordless phone for private use. Facility staff will be in-serviced on availability and location of 24 hour cordless phone for resident private use. This in-service has all been incorporated into the New Employee Hire orientation. The current Admission packet form for residents on phone use has been updated to notify new admissions of 24 hour availability of cordless phone for private use. ongoing in-servicing and new employee hire orientation will continue regarding 24 hour availability and location of cordless phone for resident private use. Location and availability of cordless phone will be posted monthly on top of the Activity calendar. 4. Corrective actions will be monitored through Resident Council meetings to ensure residents have access to phone and to determine if there are any staff education/in-servicing needs, and will be monitored through and records maintained by Staff Educator through in-servicing at hire and August 2009 facility wide in-service.	

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F 174	Continued From page 2 phone. ... there will be a portable phone in the business office during the daytime for emergency use. The nursing supervisor will carry the portable phone at night..." Review of the facility's written "Telephone" policy listed under Resident Rights (page 39) states, "The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. Guidelines 1. Telephones in staff offices or at nurse's stations do not meet the provisions of this requirement. Accommodations... include providing cordless telephones, having telephone jacks in residents' rooms... 2... At least one telephone shall be installed on each nursing floor to accommodate residents on wheelchairs... 4. A private line may be installed in the resident's room All expenses relating to the telephone are paid for by the facility." The "Telephone" policy (page 40) continues, "It is the policy of this facility to provide every resident with an opportunity to have access to a telephone for private conversations with loved ones and friends. Guidelines 1. Two (2) portable telephones are available... 2 There is no charge... for the use of the telephone. 3. The portable telephones will be kept in the Security Office. 4. ... must be logged in and out by the Security Officer..." Three CNAs (Certified Nurses Aides), E15, E16, and E17, one staff nurse, E18, and a Unit Clerk, E19, were all interviewed on 7/23/09. When asked how they would handle a resident's request for a private phone call, if the resident did not own a phone... all stated that they would take the resident to the nurses' station to use the telephone there.	F 174		

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F 174	Continued From page 3 During an interview on 7/24/09, the receptionist, E20, stated that the residents may use the portable phone available in front of the front office. 4. There were multiple observations during the survey of residents using the nurse's telephone at the 2nd and 3rd floor nurses' stations and once outside the window to the front office. There were multiple staff and/or other residents observed in the immediate vicinity during each of these phone calls. The facility failed to provide telephone access in a private area as evidenced by these observations and multiple staff and resident interviews and according to their written telephone policies.	F 174		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to ensure that 3 sampled residents (R20, R63, and R90) had signed consents with risks versus (vs.) benefits for the use of physical restraints (side rails). The facility additionally failed to ensure that R63, R20 and R90 were free from restraints that were not required to treat a medical symptom. Side rails were ordered for safety and mobility enablers, yet R63 was no longer able to use them as ordered. Findings include: cross refer F323	F 221		

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F 221	Continued From page 4 1. R63 was admitted to the facility in 2004. Diagnoses for R63 included end stage dementia with a mood disorder, CVA (stroke) and blindness. An annual MDS (minimum data set) assessment, dated 2/28/09, and quarterly MDS, dated 5/29/09, stated that R63 had severe cognitive impairment with short and long-term memory impairment. R63 was totally dependent on staff for all care, bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed) required 2+ persons physical assistance, and she required a mechanical lift with 2 persons for transfers. Review of R63's care plan for side rails, dated 3/2/09 and last updated 7/16/09, stated, "... 2 1/2 side rail... for bed mobility/an enabler to promote independence and actively participate in his/her own care...". Review of the 9/08 POS (physician order sheets) stated, "bedrails... both... *need consent signed*". Review of the clinical record, however, lacked a consent and risks vs. benefits for the use of a restraint. From 10/08 to the present, the POS' stated "... 1/2 siderails (full side rails currently in place) for safety and mobility enablers." R63 was observed on her back during multiple observations from 7/20/09 to 7/24/09. R63 was not observed turning or repositioning herself at all. It was not evident that R63 was aware that she had side rails in place. Family interview on 7/23/09 confirmed that R63 had not been able to use the rails for positioning/as an enabler for a "long time." It was	F 221	F221 1. DON and Unit Nurse Manager both spoke with the responsible party (daughter) for R63 and determined risks vs. benefits of side rail use. Daughter requested continuation of side rails use for use as an enabler for turning and repositioning and to increase resident's sense of safety and security. Resident holds onto the side rail during incontinency changes. Unit Nurse Manager obtained signed consent for side rail use, and obtained physician order for side rail use. RNAC updated care plan to reflect side rail use as an enabler for turning and repositioning and to increase resident's sense of safety and security at the request of the resident's daughter/responsible party. Unit Nurse Manager has assessed both R20 and R90 for side rail use risk vs. benefit. Side rails were determined appropriate for both residents for use in safety and use as an enabler. Responsible parties were contacted for both residents and signed consents obtained. Physician orders were verified for both residents. RNAC updated care plans.	10/15/09

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F 221	Continued From page 5 also confirmed that a consent was not signed; the family member was uncertain as to whether they were advised of risks vs. benefits for use of the rails, but stated that the family had requested them a few years ago. Facility assessments on 3/3/09 and 6/2/09 revealed that R63 did not have a medical condition that required side rails nor were they indicated and served as enablers to promote independence. Interview with E2 (Director of Nursing) on 7/22/09 confirmed that physician orders for the side rails lacked a diagnosis or medical symptoms. He also confirmed lack of a signed consent for the restraint, including risks vs. benefits. 2. R20 was admitted to the facility on 6/17/09 with diagnoses including stroke affecting her left side with poor trunk control, atrial fibulation and mental retardation. On 7/13/09, a Rehab Screening Request Form completed after R20 had a fall, revealed that E7, a Certified Occupational Therapy Aide recommended, "side rail to prevent roll out of bed". On 7/13/09, R20's physician ordered, "side rails for repositioning" and at 11 PM a nurse's note stated, "...Maintenance to be notified of order to install side rails... SP (status post) fall assessment cont. (continued) Bed in low position fall mats in place & bed alarm on". Review of the clinical record, revealed that there was no signed consent including the risks versus benefits for the use of the side rails. R20 has guardians for health and financial issues. The facility failed to obtain signed consent for the	F 221	2. All residents who have altered bed mobility, fear of falling out of bed, or who request side rails, have the potential to be affected by this deficient practice. 3. Corrective actions include updating of Side Rail Assessment form to assess risk vs benefits of side rail use and to determine individual resident need for side rail use. Assessment form includes checklist for need, risk benefit, physician order, and quarterly assessment follow up, which is done at quarterly resident care plans. Further corrective action will be that the Restorative Nurse and physical/occupational therapist will complete a weekly side rail assessment audit to determine if all Side Rail Assessment criteria are met. Unit Nurse Manager will obtain any needed documentation/intervention and RNAC will update care plans PRN and at quarterly resident care conferences. 4. Corrective Action will be monitored by DON or designee by review of the weekly side rail monitor audits. Side Rail assessment audits will be included in facility quarterly QA.	

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F 221	Continued From page 6 use of the side rails. On 7/24/09, findings were reviewed with the administrative staff at the informational meeting. 3. Resident R90 was admitted to the facility on January 31, 2009 with diagnosis including dementia, Parkinson's disease, dysphagia, depression. Admissions assessment indicated resident required total assistance. MDS was coded total assistance, two (2) person assistance for transfer, bed mobility 1 person assistance. Side rail screen assessment completed on 1/31/2009 determined that "Side rails do not appear to be indicated at this time". Observation of the resident during the survey revealed that side rails were in use for resident R90. Documentation in the resident's care plan dated 5/25/2009 revealed that 2 1/2 side rails were in use for resident R90. Care Plan approaches included "patient will fill out and sign Side Rail Consent Form". Review of the clinical record lacked a consent and risk vs. benefits Side Rail Consent form for use of the restraint. Side rails were used for R90 but were not required to treat a medical condition. Additionally the facility failed to discontinue the usage of the side rails when the facility's own assessments showed the side rails were not needed. Interview with E2, Director of Nursing, confirmed the lack of a Side Rail Consent form for the restraint use by this resident. A physician's order was obtained for the use of bilateral 1/2 side rails on 7/23/2009.	F 221		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a	F 241		

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F 241	Continued From page 7 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility failed to ensure that many residents were treated in a dignified manner. Residents were served milk in cartons during meals without being provided with beverage glasses. R72, who only had use of one hand, was unable to open her milk carton and received no assistance from staff. R29 was not served her dinner tray while other residents at her table ate their meals. R34 experienced episodes of incontinence due to call lights not being answered in a timely manner. Findings include: 1. Throughout the survey, from 7/20/09 through 7/24/09, observations were made of residents being served milk from cartons during meal times. Since no glasses were provided, residents were observed drinking directly from the milk cartons. During dining observations on 7/23/09 at 5:30 PM, R72, who only had use of one hand, asked a surveyor to open her milk carton for her as no staff was available to provide her with assistance. 2. During a dining observation on 7/23/09 at 5:30 PM, R29 was observed sitting at a table with two other residents who were eating their meals. She waited 5 to 10 minutes for her dinner, then finally asked staff if she could have her tray which she said was sitting on a table behind the cart. Staff did not attempt to serve the resident until she asked for her tray.	F 241	F241 1. Food Service Director investigated issue with R72 and R34. R72 and R34 were given glasses and additional assistance from staff in subsequent meals. R34 was discharged to home on 8/10/09. 2. All residents have the potential to be affected by this deficient practice. 3. Corrective Actions include monitoring by Food Service Director to ensure all trays with milk cartons will have beverage glasses. Wait style dining will be initiated in the facility starting October 15, 2009 and will resolve the problem of missing trays on residents who change their decision in choice of dining locations. Dietary will have a weekly test tray to ensure dishware and utensils are on resident trays. All facility staff will be in-serviced on new meal delivery system of wait style dining. Staff Educator will conduct facility wide in-servicing for staff regarding psychotropic medications having side effects of potential for urinary urgency and incontinence and that increased attention to toileting needs will be needed in cases where these medications are newly started on residents.	10/15/09

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F 241	Continued From page 8 Findings were acknowledged by E12, the Regional Food Service Manager and E13, the Food Service Director on 7/24/09. 3. R34 was admitted to the facility on 2/19/09 with diagnoses that included diabetes, cardiovascular disease, and osteoporosis. R34's admission Minimum Data Set Assessment (MDS), dated 2/24/09, coded R20 as continent of bladder and bowel, requiring extensive assistance of 1 person for toileting. The quarterly MDS, dated 5/30/09, coded R34 as occasionally incontinent of bladder, continent of bowel, requiring limited assistance for toileting. Review of the ADL Flow Records from 4/09 to present, revealed that R34 was continent of urine with the exception of incontinence recorded on 7-3 shift on 5/24, 5/25, 5/27, 5/28, 5/29/09. On 7/23/09, during an interview E10, a CNA, stated that R34 is continent and does not wear any pads. Additionally, on 7/23/09, E11, a CNA, stated that R34 is continent but the CNA did remember one incident when R34 knew that she had to go to the bathroom but could not get to the toilet in time. On 7/25/09, during an interview, R34 stated that she used a roller walker and required assistance from staff for toileting. R34 stated that in May there were a few instances of incontinence during the day related to having to wait a long time for staff to respond to her call light. This resulted in her not being able to hold her urine. The facility failed to provide care in a manner that maintained R34's dignity. On 7/25/09, findings	F 241	4. Corrective action will be monitored by the Food Service Director through a monthly Operational Score Card (roll up of a QI report) which will include test trays, tray audits, resident satisfaction surveys, and pre-service temperature results. Wait style dining service issues will be monitored on an ongoing basis at monthly Resident Council Meetings. Staff Educator will maintain in-service logs on psychotropic medication and urinary side effects.	

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F 241	Continued From page 9 were reviewed with the administrative staff at the informational meeting.	F 241		10/15/09
F 242 SS=E	483.15(b) SELF-DETERMINATION AND PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based upon observation, interviews and document review the facility failed to reasonably accommodate preferences of residents related to food choices for 4 residents (R62, R41, R13 and R6). Additionally, Resident Council Meetings in the past 3 months noted that items were missing from trays. R13 and R41 had items listed on their meal tickets that were missing when test trays were assessed by surveyors. R62, a resident with diabetes, incorrectly had sugar packets on his tray. R6 was receiving a mechanical soft diet when she had been requesting and ordered to receive a regular diet. Findings include: Review of Resident Council meeting minutes from 4/09, 5/09 and 6/09 revealed that residents expressed concern that items were often missing from meal trays. Additionally, residents complained that specific food requests were not always honored. On 7/20/09, in an interview with R15, the Resident Council President, she confirmed that there were multiple complaints about food trays at the meetings.	F 242	F242 1. Food Service Director will meet with R62, R41, R13, and R6 to investigate issues further and plan any resident specific interventions. Food Service Director will inservice dietary staff. 2. All residents have the potential to be affected by this deficient practice. 3. Tray accuracy audits to be completed weekly with a mandatory 100% compliance from dietary staff. Tray accuracy audits will be tracked weekly and posted in Operational Scorecard. 4. Corrective action will be monitored by the Food Servcie Director through monthly Operational Scorecard which will include test trays, tray audits, resident satisfaction surveys, and pre-service temperature results.	

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F 242	Continued From page 10 1. R62 was admitted to the facility on 5/15/09 with diagnoses including insulin dependent diabetes and stroke. The 7/09 physician order sheet (POS) listed R62's diet as carbohydrate controlled diet (CCD). On 7/23/09, R62 incorrectly received 6 sugar packets on his dinner tray instead of the 6 sugar substitute packets despite the meal ticket which listed R62's diet as CCD with 6 sugar substitute packets. R62 also stated that his salt packet was wet and unable to be used. The facility failed to provide choices consistent with R62's plan of care due to incorrectly giving him sugar on his dinner tray and an unusable salt packet. On 7/23/09, findings were acknowledged by E14 (unit clerk) who called the kitchen to request the sugar substitute and salt packets. 2. On 7/23/09, R41 agreed to let surveyors use his dinner tray as a test tray. When the tray was assessed the following items were missing: 8 oz. water, 1 pepper packet, and 1 margarine. The facility failed to provide items R41 had chosen to be on his tray. 3. R13 was admitted to the facility with diagnoses that included emphysema, weight loss and severe gastritis. During an interview with R13 on 7/21/09, he stated that he had asked for oatmeal and boiled eggs for breakfast, but he did not always receive them. He stated that since he only had bottom teeth he could not chew everything and that he asked to have oatmeal at every meal but he rarely received it. Additionally, he stated that he asked for three sugars on each meal tray but he usually did not receive them.	F 242		

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F 242	Continued From page 11 Review of R13's breakfast meal tickets on 7/21/09, 7/22/09 and 7/23/09 indicated that two boiled eggs should have been on the trays, however, no eggs were observed. On 7/23/09, R13's dinner tray was pulled as a test tray. The meal ticket indicated that the tray should have included cottage cheese, margarine, two peppers, and 3 sugars. Observation of the tray revealed that these items were missing. On 7/24/09, R13's lunch ticket indicated that oatmeal should have been on the tray, but no oatmeal was observed. The facility failed to honor R13's choices. 4. R6 was an alert an oriented resident. During a dining observation on 7/20/09 at 12:40 PM, R6 was observed in the dining room eating lunch. Her meal ticket indicated that she received a mechanical soft diet which she did receive for that meal. R6 stated that she had been asking the facility for regular food but they were not listening to her. During an interview with the dietitian, E8 on 7/20/09, she stated that she thought that speech therapy did not feel that R6 could handle regular food. She later stated that she spoke with the speech therapist who stated that the resident was cleared to receive a regular diet. E8 stated that she corrected R6's diet orders. An interview with R6, on 7/21/09 at 9:00 AM, revealed that she received ground food which she did not like. During a dining observation on 7/24/09 at 12:30 PM, R6 stated that she was still receiving	F 242		

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F 242	Continued From page 12 chopped food. Shortly after the interview, staff was observed serving R6 a regular hamburger, however, there was no meal ticket that accompanied her dinner to reflect the change in the resident's diet. The facility failed to honor the dietary requests of R41, R13 by omitting items from their meal trays and for R6 by not providing her with the food consistency that she requested. Findings were acknowledged by E12, the Regional Food Service Manager and E13, the Food Service Director on 7/24/09.	F 242		10/1/09
F 247 SS=B	483.15(e)(2) NOTICE BEFORE ROOM CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview it was determined that the facility failed to inform at least one (1) sampled resident (R86) of a roommate change. Findings include: Through resident Interviews and staff interview, E9, the facility social worker, residents do not receive advanced notice of a roommate change.	F 247	F247 1. No specific intervention was done with R86 but as a result of situation, Social Service Director developed a Roommate Change notification form. 2. All residents have the potential to be affected by this deficient practice. 3. All resident room changes/roommate changes must be authorized by Social Services or designee (Admissions Director). Social Service Director will meet with roommate of resident leaving a room, or roommate to receive another resident into the room, and have resident sign notification form of roommate change.	
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	4. Corrective action will be monitored by Social Service Director by follow up on each resident room change to ensure Roommate Change form has been initiated and completed.	

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F 248	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to provide an ongoing activity program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being for 2 (R8 and R20) sampled residents. The facility failed to follow the care plan and assessments developed for R8 regarding activities of interest. The facility failed to provide additional in room activities appropriate for R20 after she sustained a humeral fracture in the facility. Findings include: Cross refer to F250 1. R8 was admitted to the facility in 3/05. Her diagnoses include: language barrier and Alzheimer's dementia with depression. The facility care planned for "... impaired communication related to: language barrier, resident speaks: Chinese." Approaches included, "... 4. Use gestures when necessary... 7. Family to assist with translation... 9. Involve resident in activities which do not depend on resident's ability to communicate: music, parties, movies, etc...". On 11/28/09, the approach "Chinese newspapers/literature, etc. have stopped coming to the facility. Family made aware. States they will amend." The care plan was developed on 7/23/08 and was last reviewed on 2/23/09. A "potential for social isolation d/t (due to) language barrier" care plan, developed on 6/19/08 and last revised on 5/29/09, listed goals including, "... continue to get needs satisfied through family visits, and 1:1 room visits, invitation to group activities of choice daily."	F 248	F248 1. Corrective actions put into place by Activity Director for resident R8 include: - Daily "Meet and Greet" (schedule of daily activities and menus) will be provided in Chinese. Staff will review with resident each morning and encourage resident to choose 1 group activity she would like to attend. Staff will follow up with invite to stated activity and document participation or refusals daily. - Use phone translator, resident's family, and two staff members (staff educator and 3-11 C.N.A.) as needed to translate for resident and staff to aid in clearer communications. - Connect resident with community organizations/churches with members from native country who speak native language. - Family to provide resident with publications of native language for daily reading or as desired by resident. - Provide videos, documentaries/movies of native language weekly or as desired by resident to watch independently in room. Use Netflix as primary resource. A DVD player was purchased for resident. Corrective actions for R20	10/1/09

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F 248	Continued From page 14 Approaches included, "... Will continue to invite and escort to programs of interest... will invite to facilities bus trip program at least once per month "Shopping"... Provide daily room visits...". The facility also care planned for "Resident is being treated for indicators of depression i.e. hopelessness, sadness, withdrawal, etc." on 7/23/08 (updated on 2/23/09). Approaches included, "... 4. Encourage to attend and participate in activities of known interest. 5. Meet with on a 1:1 basis and encourage expression of feelings... 10. Encourage family/pet visits." R8's annual MDS (minimum data set) assessment, dated 2/21/09, listed general activity preferences as arts/crafts, exercise/sports, music, watching TV, and talking or conversing. Activity sheets from 2/09 to 7/09 were reviewed. The majority of activities R8 attended and was "active" in included, meet and greet, word games/trivia/reminisce, and movie/video/TV. R8 actively participated in party/social entertainment 5 times and she declined this activity 13 times. She actively participated in food socials/breakfast club/monthly birthday parties 11 times, while declining the activity 10 times. She attended arts and crafts/ceramics once in over 5 1/2 months and declined once, and she actively participated in exercise/active games 5 times. Exercise/active games was declined once and another time R8 napped through the activity. The only outing or bus trip listed was a leave of absence with R8's family on 4/6/09. There was no documentation of 1:1 visits or pet visits. During an interview with E21 (activity aide) on 7/24/09, E21 stated that although R8 was social,	F 248	include: - Activity Director is now attending daily clinical meeting to be informed of any significant change in resident status that potentially could affect leisure participation. - Care plans will be updated and revised on quarterly basis or with significant change by Activity Director. - Activity Director will hold daily meetings with activity staff to discuss any change in residents' status regarding activity participation. -Communication book was eliminated. Speech therapist designed a Chinese communication board with pictures for resident. Social Worker posted in resident's room and staff were in-serviced on use of Chinese communication board. 2. All residents have the potential to be affected by the deficient practice. 3. For resident R8: - All activity staff will be in-serviced on proper documentation of refusals and active participation vs. passive participation.	

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F 248	Continued From page 15 because of the language barrier, R8 refused many activities. E21 stated that R8 liked watching TV, music, having her nails done, and shopping. E21 stated that R8 used to get Chinese magazines and she was "looking into that." Activity sheets from 2/09 to 7/09 were reviewed with E21. E21 confirmed that 1:1 visits were not provided to R8 nor was R8 offered out of facility bus trips at least once per month. E21 stated that the last time she recalled R8 going on a bus trip was an ice cream social last year. E21 confirmed that R8's care plan for activities was not followed. E26 (CNA) and E27 (CNA) were interviewed on 7/24/09. E26 and E27 stated that R8 sits on the couch in the lounge in front of the nurses station on the floor in which she resides watching people. They stated that R8 does not watch TV in the lounge and they had not observed R8 engaged in word games/trivia/reminisce, although activity sheets indicated that R8 actively engaged in these activities nearly every day. They stated R8 watched Chinese movies in her room that her family provided, however, most of the time she would fall asleep. A Care Conference Record for R8, dated 5/29/09, stated, "... does not interact c (with) staff or residents. + (positive) Language barrier- res. speaks Chinese and 0 (no) English but is cooperative... Activities of choice. May refuse invitation by staff. No concerns." Multiple observations from 7/20/09 to 7/24/09 revealed R8 sleeping on top of her bed at various times of the day (morning and afternoon) and/or sitting quietly on the couch in the lounge in front of the nurses station looking around. R8 was not observed actively watching TV or engaging in any	F 248	- Activity Director will monitor participation logs weekly for missed documentation or improper documentation by staff for immediate correction. - Significant decline in activity participation will be defined as an increase in refusal of activities of interest by at least 30% in a 2 week period. - Quarterly documentation in medical record will clearly indicate leisure participation in groups and individual activity and extent of involvement i.e. refused, active, passive, etc. Care plans will be updated or revised to indicate goal achievement or decline. Care plans will be updated to clearly indicate specific leisure interest. For resident R20: - In addition to quarterly updates, Activity Director will review care plans at interdisciplinary care plan meetings. Residents with significant change in status affecting leisure participation will be put on a 1:1 or provided with adaptations to enable continued participation in leisure activities of choice. 4. Corrective actions will be monitored for resident R8: - Participation logs will be monitored weekly to ensure proper documentation by staff, of independent and group participation. - Activity Director will implement quarterly QI study to track	

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F 248	Continued From page 16 activities during the survey. Staff (including activity staff) were not observed trying to communicate upcoming activities to R8 and they were not seen encouraging R8's participation in activities she attended. No family members or visitors were seen during the survey. On 7/23/09, E28 (activity aide) was observed talking to multiple residents on the 2nd floor lounge while baking cookies. Most of the residents were gathered near E28. They were offered drinks while the cookies baked and then asked if they preferred sugar or chocolate chip cookies. R8 sat on the couch in the lounge away from the other residents, was not offered or given a drink and she was not given a choice of cookies. The only conversation from E28 to R8 during the activity was when R8 held her hands out when the cookies were given to her, E28 stated, "be careful, it's hot." R8 quietly ate her cookies. An activity note, dated 7/2/309, stated, "... decline (sic) to participate with baking, after finishing baking she enjoyed tasting the cookies." During the survey, a trainer with the survey team got a Beijing website on her laptop which she shared with R8. R8 became excited and clapped her hands to the music and she actively read the newspaper in Chinese. The facility failed to follow R8's care plan with regard to activities. 2. R20 was admitted to the facility on 6/17/09 with diagnoses including stroke affecting her left side with poor trunk control, atrial fibulation and mental retardation. On 7/14/09, R20 fell out of bed and fractured her left humerus (Upper arm/shoulder). The Initial Assessment for Activities, dated	F 248	participation in activities of interest for those residents care planned for language barrier. - Activity Director will continue to monitor participation logs to ensure independent leisure activities such as movies, volunteer visits and publications/materials are being provided weekly. Corrective actions will be monitored for R20: - Activity Director will implement quarterly QI study to track any resident with significant change is appropriately care planned and any interventions have been put in place and are effective. - With any readmit to facility post hospital stay, Activity Director will review care plan and implement any necessary changes.	

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F 248	Continued From page 17 6/26/09, recorded that R20 's vision was adequate with glasses, she had good hearing, used verbal communication and was able to make her needs known. The assessment listed R20's current interests as games including Bingo and Pokino, crafts, exercise, music, reading, watching TV and talking. The Activity Care Plan, dated 6/26/09, had a plan of action including group activities on and off unit and to encourage independent activity such as watching TV and providing reading materials for R20 to use. Multiple observations were made on 7/20, 7/21 and 7/23 of R20 laying awake in her bed, without the TV on, books to read, or listening to music. There were no observations from 7/20/09 through 7/23/09 of R20 actively participating in any crafts, games, or group activities. The Activity Log recorded that R20 actively participated in "Meet and Greet/Morning Chat/Snack & Chat", "Word Games/Trivia/Reminisce" and Movie/Video/TV" on 7/20, 7/21, 7/22, 7/23. On 7/24/09, an interview with E21 Activity Aide, revealed "Meet and Greet" can be a brief visit into the residents' rooms. E21 also stated that at times R20, "will be by the nurses' station while activities are occurring and will watch an activity." E21 stated that there had not been revisions to the Activities program for R20 after her fracture. The facility failed to provide for an ongoing program of activities designed to meet R20's needs based upon her change in status. On 7/24/09, findings were acknowledged by E21 and findings were reviewed on 7/25/09 with the	F 248		

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F 248	Continued From page 18 administrative staff at the informational meeting.	F 248		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interview, it was determined that the facility failed to provide medically-related social services to attain or maintain the highest practicable psychosocial well-being for one sampled resident (R8). R8, a Chinese speaking resident, had unmet needs related to difficulty with personal interaction and socialization skills. Findings include: cross-refer F248, example #1 R8 was admitted to the facility in 3/05. Diagnoses for this resident included a language barrier and Alzheimer's dementia. The facility care planned for (dated 7/23/08 and last revised on 2/23/09) "... impaired communication related to: language barrier, resident speaks: Chinese." Approaches included, "... 3. Check for feedback to assure comprehension; repeat when necessary. 4. Use gestures when necessary... 7. Family to assist with translation. 8. Provide reassurance and encouragement if resident attempts to communicate... 10. Chinese newspapers/literature, etc. have stopped coming to facility. family made aware. States they will	F 250	F250 1. Social Service Director met with Speech Pathologist and a communication assessment was done on R8. Speech therapist will trial a communication board with resident and then in-service the staff once an appropriate communication board is finalized. Social Service Director created a "Sensory Assessment" tool. 2. All residents have the potential to be affected by the deficient process. 3. Social Service Director will conduct ongoing assessments of communication barriers and needs of residents at admission/readmission and quarterly. Social Service Director will assess resident to identify sensory impairments. Social Service Director will then make community referrals in order to obtain needed services for residents. 4. Corrective action will be monitored by Social Service Director through resident quarterly care conferences and QI.	10/1/09

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F 250	Continued From page 19 amend (added to care plan on 11/28/08)." A social service note, dated 3/18/08, stated, "... Family presents as supportive, visiting often and interpreting as needed." A Care Conference Record for R8, dated 5/29/09, stated, "... does not interact c (with) staff or residents. + (positive) Language barrier- res. speaks Chinese and 0 (no) English but is cooperative... No concerns...". Nurses notes (NN) dated 6/25/09, stated, "... Communication Barrier interferes c (with) Residents ability to communicate needs...". A NN, dated 7/1/609, stated, " ...Language Barrier creates communication problem...". On 7/21/09, the surveyor tried to converse with R8 and R8 waved the surveyor away. E24 (medication nurse assigned to R8) replied that R8 does not fully understand English and stated it was difficult to know what she understands. E24 stated she believed R8 was oriented and she stated that staff communicated with R8 mostly with hand signals, ie- pointing to things. E24 stated there was currently no one in the facility to interpret for R8. E24 stated that R8 provided her own ADL's, including toileting, but it was difficult to obtain information such as when R8's last bowel movement was. E24 stated she had worked in the facility about a year and wanted to set up pictures to communicate with R8, but there was currently nothing in place. During an interview with E21 (activity aide) on 7/24/09, E21 stated that although R8 was social, because of the language barrier, R8 refused many activities. E21 stated that activity staff	F 250		

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F 250	Continued From page 20	F 250		

communicated with R8 using hand gestures and stated that 2 employees on day shift spoke Chinese; 1 fluently and the other a few words. E21 stated there was no one to communicate with R8 on evenings or nights.

E26 (CNA) and E27 (CNA) were interviewed on 7/24/09. When asked how often R8's family visited, E26 and E27 stated they did not know, but they did not see anyone on day shift. They stated that R8 "likes to keep to herself" and most of the time she would fall asleep in her room. E26 and E27 stated that R8 was "more spunky" when she first came to the facility. They stated R8 never talked much, but could say yes and no. When asked how they would know if something was wrong with R8 if she was unable to communicate her needs, they replied that if R8 did not get up for a few days at her normal time, they would call the nurse to check R8. When asked if there were any devices to aid with communication for R8, E26 and E27 stated no. When they searched R8's room, however, they found a communication book (appeared brand new) that included pictures; E26 and E27 stated they had never seen it before.

Multiple observations from 7/20/09 to 7/24/09 revealed R8 sleeping on top of her bed at various times of the day (morning and afternoon) and/or sitting quietly on the couch in the lounge in front of the nurse station looking around. R8 was not observed actively watching TV or engaged in any activities during the survey.

During the survey, a trainer with the survey team got a Beijing website on her laptop which she shared with R8. R8 became excited and clapped her hands to the music and she actively read the

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F 250	Continued From page 21 newspaper in Chinese. No family members or visitors were seen during the survey, although the facility identified in R8's care plan and social services stated that R8's family was to translate. During the informational meeting on 7/24/09, E9 (social services) stated that the facility had compiled a list of translators for multiple languages to be used as needed. She stated that she was unaware that the list was not being used by staff for R8. Although the facility identified and care planned that R8 had impaired communication and a language barrier, they failed to provide sufficient and appropriate social services to improve R8's communication and as a result, she was isolated. It was unclear whether the communication book was placed in R8's room after the survey started, however, it was unknown to staff interviewed that a communication device and a list of translators (except for social service) existed for R8. Additionally, social services failed to provide assistance related to activities of interest when the resident's Chinese newspapers and literature stopped coming into the facility in 11/08. Although R8's family previously provided reading materials, it is the responsibility of the facility to identify the social service needs of the resident and to assure that the needs are met by the appropriate disciplines.	F 250		
F 256 SS=D	483.15(h)(5) ENVIRONMENT- LIGHTING The facility must provide adequate and comfortable lighting levels in all areas.	F 256		

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F 256	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based upon observation, interview and record review the facility failed to provide adequate and comfortable lighting levels for 2 residents (R39 and R41). Findings include: 1. R39 had diagnoses including glaucoma and cardiovascular disease. The annual Minimum Data Set Assessment (MDS) dated, 3/9/09, coded R39's short and long term memory as "OK" and vision as visually impaired. The quarterly MDS, dated 6/7/09, continued to code R39's short and long term memory as "OK". R39's care plan, dated 3/10/09, for impaired vision/glaucoma stated, "Maintain a safe environment at all times, adequate lighting..." On 7/20/09, during an interview, R39 stated that there is not enough light in her room to read books, etc. The facility failed to provide adequate additional lighting for R39 in her room. On 7/25/09, findings were reviewed with the administrative staff at the informational meeting. 2. R41 was admitted to the facility in 5/06 with diagnosis that included cardiac dysrhythmia , hypertension, peripheral vascular disease, cataracts and glaucoma. The annual Minimum Data Set Assessment (MDS) dated, 4/20/09, coded R41's short and long term memory as "OK". The quarterly MDS, dated 7/20/09, continued to code R41's short and long term memory as "OK". R41's care plan, dated 7/31/08, for impaired vision stated, "Maintain a safe environment at all times, adequate lighting..." On 7/20/2009 and again on 7/24/2009 at 3:15 PM	F 256	F256 1. Maintenance Director checked both R39 and and R41's room lighting for actual needs and residents' preferences for lighting. The Maintenance Director replaced the existing light bulbs with higher wattage lightbulbs. Both residents were examined by the Optomotrist and were assessed as having no significant optical changes or additional refraction needs. Monthly room inspection report has been amended to include lighting preferences for all residents. 2. All Residents have the potential to be affected by the deficient practice. 3. Maintenance Director updated present "Room Maintenance Report". Room lighting was amended to include if lighting was satisfactory to resident's visual needs. Room Maintenance Report will continue to be used on a monthly basis. 4. Corrective action will be monitored by Maintenance Director through Monthly Room Maintenance Reports. Reports are kept by Maintenance Director in a series of room binders and findings will be reported at Quarterly QI meetings.	9/1/09

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F 256	Continued From page 23 during an interview R 41 stated his room is dark and it was never that way before. Observation of R 41 on 7/24/2009 revealed that the Left eye appeared red and swollen. Interview with the Charge nurse (E5) on 7/24/2009 at 3:40 PM revealed that she was unaware that the resident complained of the room being dark. E5 confirmed that R 41 had almost no vision in his left eye. E5 spoke with the RNAC (E28) and she confirmed the decreased vision in R41's left eye. The facility failed to provide adequate lighting for R41 in his room. On 7/25/09, findings were reviewed with the administrative staff at the informational meeting.	F 256		10/15/09
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F279 1. R63's antipsychotic care plan was adjusted to indicated side effects. Further care plans regarding anxiolytic use will be updated as needed. R61's dialysis care plan will be updated as needed. 2. All residents have the potential to be affected by deficient practice. 3. Corrective actions include DON obtaining resident antipsychotic and anxiolytic list from pharmacy for RNAC. RNAC revised care plans for listed residents to specify antipsychotic/anxiolytic medications and each medication's individual side effects. AIMs testing will be done at admission (baseline assessment), upon start of antipsychotic therapy, and every 6 months after. The facility devised an Interdisciplinary Dialysis Communication tool for use in resident status reporting between facility and dialysis center. The RNAC will revise all resident anxiolytic and dialysis care plans to reflect medication side effects and the dialysis communication as needed. DON obtained behavior sheets and placed on MAR's for nurse monitor. Staff Educator will in-service on AIMs testing, Behavior sheets, and Interdisciplinary Dialysis Communication tool.	

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F 279	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, it was determined that the facility failed to ensure that comprehensive care plans were developed for 2 residents (R61 and R63) that addressed the residents' nursing needs. Although the facility care planned for the potential for psychotropic drug-related side effects related to taking the antipsychotic (Seroquel) and anxiolytic (antianxiety- Ativan) medications for R63, they failed to list specific side effects (including behaviors) related to these medications, they failed to identify how they were going to monitor for effectiveness and side effects of the medications, and they failed to list lesser alternatives (non-drug interventions) before administering Ativan. Additionally, the facility failed to perform an AIMS (Abnormal Involuntary Movement Scale) test when R63 was started on Seroquel. R61's dialysis care plan lacked information regarding the coordination of services between the facility and the dialysis center. Findings include: 1. Diagnoses for R63 included end stage dementia with a mood disorder and blindness. The 7/09 POS (physician order sheet) revealed that R63 received Seroquel (antipsychotic) 25 mg twice a day and Ativan (antianxiety) 1 mg every 6 hours as needed for agitation/aggression that was ordered on 5/26/09. Care plans were developed on 6/1/09 for the potential for psychotropic drug-related side effects related to taking antipsychotic and anxiolytic medications. Approaches listed on the care plan included, "1. Medicate... per MD order and monitor for effectiveness and side effects of	F 279	DON will continue to provide RNAC with a pharmacy list each month of residents on antipsychotics and anxiolytics to ensure proper care planning. DON will obtain a list of residents on antipsychotics from pharmacy for staff to ensure baselines and q6 month monitoring of AIMs are completed. Unit Managers on both nursing floors will monitor return receipt of forms and file on resident's chart. All staff will be in-serviced on the Interdisciplinary Dialysis Communication tool. 4. Corrective actions will be monitored by the following: RNAC will monitor care plans quarterly at MDS generation to ensure proper care planning of antipsychotics, anxiolytics, and dialysis communication tool. Unit Managers will ensure q6month completion of AIMs prior to resident care conference per list of weekly MDS's to be generated, by RNAC. Unit Managers will monitor for proper Behavior sheet documentation on a weekly basis. Improper documentation (AIMs and Behavior sheets) by nursing staff will be reported to the DON for follow up with the individual staff member. Staff Educator will maintain in-servicing records on the Interdisciplinary Dialysis Communication tool.	

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F 279	Continued From page 25 medication.... 4. Monitor and document signs/symptoms of adverse effects as well as positive effects from the drug. These approaches were generic; the facility failed to list specific side effects (including behaviors) related to the medications and they failed to identify how they were going to monitor for effectiveness and side effects of the medications. Review of the anxiolytic care plan additionally listed the approach, "... 7. Explore ways to eliminate anxiety with resident...". An annual MDS (minimum data set) assessment, dated 2/28/09, and quarterly MDS, dated 5/29/09, stated R63 had severe cognitive impairment, short and long-term memory impairment, and communication problems. R63 was not capable of exploring ways to eliminate anxiety. The facility failed to identify and list ways in which to reduce and/or eliminate anxiety for R63 and they failed to list lesser, non-drug interventions to consider/use before administering Ativan to R63. Findings were confirmed with E4 (Unit Manager) and E22 (Medication Nurse) on 7/23/09. E4 stated the only place behaviors were documented are on ADL flow sheets (completed by CNA's) and on the back of the Ativan medication administration record. Additionally, interviews with E2 (Director of Nursing) and E4 confirmed that the facility failed to perform an AIMS (Abnormal Involuntary Movement Scale) test when Seroquel was started on 5/26/09. They stated it was facility practice (confirmed in review of the facility AIMS testing policy) to do it 6 months after an antipsychotic was started and every 6 months thereafter; their practice did not include a baseline AIMS test. The facility failed to have a baseline AIMS test when R63's Seroquel was started on	F 279		

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F 279	Continued From page 26 5/26/09 so that a comparison could be made 6 months later to assess for any changes. 2. R61 had a diagnosis of renal failure and received renal dialysis at an outside dialysis center three days per week. Review of R61's Care Plan titled, "Dialysis/Renal Failure", last updated on 3/17/09 listed ten approaches, including "10. Dialysis at: (name of dialysis center), Days and time: T-Thur-Sat." The care plan lacked approaches for the coordination of services between the facility and the dialysis center. Additionally, the care plan lacked approaches for monitoring vital signs of the resident before and after dialysis treatments. The facility failed to develop a comprehensive care plan for R61's dialysis treatments that addressed the coordination of services between the facility and the dialysis center. Findings were acknowledged by the administrative staff at the informational meeting on 7/24/09.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	F280 1. Corrective actions for R8 were care plan updating by Activity Director to activity care plan including: - Daily "Meet and Greet" (schedule of daily activities and menus) will be provided in Chinese. Staff will review with resident each morning and encourage resident to choose 1 group activity she would like to attend. Staff will follow up with invite to stated activity and document participation or refusals daily.	10/1/09

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F 280	Continued From page 27 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to review and revise care plans for 7 sampled residents (R8, R13, R20, R41, R63, R75, and R84). Findings include: cross-refer F221 1. Review of R63's care plan for side rails, dated 3/2/09 and last updated 7/16/09, stated, "Resident has requested to use a side rail... for bed mobility/an enabler to promote independence and actively participate in his/her own care...". Approaches included, "1. Patient will fill out and sign Side Rail Consent Form... 3. Continued patient education on the safe use of side rails and encouraging use of alternative devices instead...". R63 had end stage dementia and blindness. An annual MDS (minimum data set) assessment, dated 2/28/09, and quarterly MDS, dated 5/29/09, stated R63 had severe cognitive impairment, short and long-term memory impairment, and communication problems. R63 was not capable of requesting side rails, signing a consent form, or remembering patient education. Side Rail Screen Assessments, dated 3/3/09 and 6/2/09, indicated "... 10. Has the resident expressed a desire to have side rails while in	F 280	- Use phone translator, resident's family, and two staff members (staff educator and 3-11 C.N.A.) as needed to translate for resident and staff to aid in clearer communications. - Connect resident with community organizations/churches with members from native country who speak native language. - Family to provide resident with publications of native language for daily reading or as desired by resident. - Provide videos, documentaries/movies of native language weekly or as desired by resident to watch independently in room. Use Netflix as primary resource. A DVD player was purchased for resident. Corrective actions for R20 include: - Activity Director is now attending daily clinical meeting to be informed of any significant change in resident status that potentially could affect leisure participation. - Care plans will be updated and revised on quarterly basis or with significant change by Activity Director. - Activity Director will hold daily meetings with activity staff to discuss any change in residents' status regarding activity participation	

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F 280	Continued From page 28 bed? N (no)... At this time, side rails are indicated per family request...". Family interview on 7/23/09 confirmed that the family requested the side rails a few years ago and confirmed that R63 had not been able to use the rails for positioning/as an enabler for a long time. Findings were reviewed during the informational meeting on 7/25/09. cross-refer F248 2a. Review of R8's care plan for communication, dated 7/23/08 and last updated 2/23/09, stated, "... has impaired communication related to: language barrier, resident speaks: Chinese." Approaches listed included, "... 4. Use gestures when necessary... 7. Family to assist with translation. 8. Provide reassurance and encouragement if resident attempts to communicate. .." A Nurses' Note (NN), dated 6/25/09, stated, "... Communication Barrier interferes c (with) Residents ability to communicate needs...". A NN, dated 7/16/09, stated, "... Language Barrier creates communication problem..." E24, a medication nurse, stated she believed R8 was oriented and that staff communicated with R8 mostly with hand signals, i.e.- pointing to things. E24 stated there was currently no one in the facility to interpret for E8. E27, a CNA, and E28, a CNA, were interviewed on 7/24/09. When asked how often R8's family visited, E27 and E28 stated they did not know, but they did not see anyone on day shift. When asked if there were any devices to aid with communication for R8, E27 and E28 stated," no".	F 280	-Communication book was eliminated. Speech therapist designed a Chinese communication board with pictures for resident. Social Worker posted in resident's room and staff were in-serviced on use of Chinese communication board. R13's care plan was updated to reflect need for properly fitting dentures and plan for obtaining dental services. Resident has a dental appointment on 10/29/2009, R20 was discharged to home with family/caregiver, R41's care plan was adjusted to reflect use of interdisciplinary communication tool for information reporting by dialysis to nursing home, R63's care plan was changed to reflect side rail use for turning and repositioning and to increase resident's sense of safety and security per request of daughter, R75's care plan was updated to reflect eye exam and findings with standard nursing care and Restorative nursing with use of MAFO for ambulation, and R84 has been discharged to the hospital.	

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F 280	Continued From page 29 However, when they searched R8's room, they found a communication book (appeared brand new) that included pictures. Both E27 and E28 stated they had never seen it before. Although communication continued to be a problem for R8, the facility failed to revise R8's care plan to include a communication book and/or measures other than using gestures to communicate with R8 and failed to include a list of translators to aid in communication. 2b. Review of R8's care plan for Activities, last updated 5/29/09, stated, " Potential for social isolation d/t (due to) language barrier..." Approaches listed included, "will continue to invite and escort to programs of interest; will remind resident of up-coming events; will encourage independence and own choices; ... encourage socialization and out of room activity; encourage continued family involvement..." E21, an activity aide was interviewed on 7/24/09, and stated that although R8 was social, because of the language barrier, R8 refused many activities. E21 acknowledged that the Activity care plan needed to be revised with additional approaches so that R8 would be able to understand and participate in activities of choice. The facility failed to revise the Activity care plan to meet R8's current interests. Findings were reviewed during the informational meeting on 7/25/09. Cross refer to F 325 3. R 84 was admitted on 2/17/2009 with diagnosis which included hypertension, schizophrenia, emphysema and cancer. On the 7/20/2009 the	F 280	2. All residents have the potential to be affected by deficient process. 3. Activity Director now attends daily nursing report to obtain any resident updates and or change in status for care planning change/update purposes. RNAC will revise ADL care plans to reflect specific needs of resident nail care. A "Hygiene Technician" position has been created and will be implemented by September 15, 2009. The hygiene technician will be a C.N.A. responsible for showing and bathing activities, and nail care. Unit Mangers will address with hygiene tech which residents should not have nails clipped. 4. Corrective action will be monitored by the RNAC. RNAC will receive copy of weekly Side Rail audit and adjust care plans accordingly. RNAC will audit for proper completion of sensory	

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F 280	Continued From page 30 physician's history and physical included the diagnosis of brain aneurysm, anxiety and pain. The facility developed a care plan for alteration in nutrition and hydration dated 2/20/2009 and revised on 6/28/2009 and 7/24/2009. This included a goal of no significant weight loss through next review, and weight to remain above 145 pounds. The approaches included supplements as ordered, med pass 4 ounce three times a day, preferences obtained, sandwiches as ordered and document on MAR. Under evaluation the dietician wrote on 7/24/2009 weight at 129 pounds, will monitor at high risk. While the care plan identified periods when the resident lost weight it failed to identify the 7.8% weight loss in 3 months. Additionally the complete care plan failed to mention or identify the resident's diagnosis of COPD and how that would impact on R84's caloric requirements. Cross refer to F 256, example #2 4. R41 was admitted to the facility in 5/06 with diagnosis that included cardiac dysrhythmia , hypertension, peripheral vascular disease, cataracts and glaucoma. While the facility developed a care plan for R41's dated 7/31/08 for impaired vision it failed to be revised to include the information that R41 had almost no vision in his left eye. E5 confirmed that R41 had almost no vision in his left eye. E5 spoke with the RNAC (E28) and she confirmed the decreased vision in R41's left eye. The facility failed to review and revise the care plan to include this information. On 7/25/09,	F 280	(eyes, hearing, communication/language, dental) care plans at resident quarterly care conference and alert Social Services of any needs not addressed and needing attention. RNAC will audit for proper care planning of activity care plans at quarterly resident care conferences and alert Activity department of any needs not addressed and needing attention. RNAC will audit for proper care planning of nutritional care plans at quarterly resident care conference and alert Dietician of any needs not addressed and needing attention. Follow up to care plan revisions will be done by RNAC as needed and RNAC will address any outstanding care planning needs with specific interdisciplinary members to remedy.	

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F 280	Continued From page 31 findings were reviewed with the administrative staff at the informational meeting. 5. R20 was admitted to the facility on 6/17/09 with diagnoses of stroke affecting her left side and mental retardation. On 7/14/09, R20 fell out of bed and fractured her left humerus (Upper arm/shoulder). R20's Activity Care Plan, dated 6/26/09, had a plan of action including group activities on and off unit, encourage independent activity such as watching TV, provide reading materials. The Initial Assessment for Activities,dated 6/26/09, listed current interests as games including Bingo and Pokino, crafts, exercise, music, reading, watching TV, and talking. Multiple observations were made on 7/20, 7/21 and 7/23 of R20 laying awake in her bed, without the TV on, books to read, or listening to music. On 7/24/09, an interview with E21 revealed that the facility had not revised the Activities Care Plan for R20 in light of her fracture to provide any additional appropriate activity interventions. The facility failed to revise the Activity Care Plan as R20's status changed. On 7/25/09, findings were reviewed with the administrative staff at the informational meeting. 6. R75 was readmitted to the facility on 4/21/09 with diagnoses including Alzheimer's Disease, depression and cardiovascular disease. A significant change Minimum Data Set (MDS) Assessment, dated 4/28/09, coded R75's	F 280		

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F 280	Continued From page 32 personal hygiene as extensive assistance with one person assist and coded bathing as physical help of one person. On 7/20/09 and 7/23/09, observations were made of R75 with fingernails that were long with dirt under them. The facility failed to revise the ADL care plan, dated 5/8/09, to specify nail care for R75. On 7/25/09, findings were reviewed with the administrative staff at the informational meeting. Cross refer to F411 7. Observations of R13 throughout the survey, from 7/20/09 through 7/24/09, revealed that he had no top teeth. Top dentures were observed on his bedside table. During an interview with R13 on 7/21/09, he stated that he could not wear his top dentures since they no longer fit properly. Review of R13's "Dental" care plan revealed that the resident had his own bottom teeth and "dentures to top." There was no indication in the care plan that the resident did not wear his top dentures due to the fact that they no longer fit him properly. The facility failed to revise R13's "Dental' care plan to indicate his need to have his top dentures refitted. Findings were acknowledged by administrative staff at the informational meeting on 7/24/09.	F 280		
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311		

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F 311	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based upon observation, interview and record review, it was determined that the facility failed to provide appropriate treatment and services to maintain or improve abilities for 1 sampled resident (R75). The facility failed to follow up when an orthotic device arrived which R75 was to use. Findings include: R75 was readmitted to the facility on 4/21/09 with diagnoses including dementia with delusions and depression. On 5/6/09, R75's physician ordered an ankle foot orthosis to the left lower extremity for foot drop. Observations made on 7/20/09 and 7/23/09 revealed that the ankle/foot orthotic was in front of the bedside stand and not being used by R75. Additionally, on 7/23/09, E23 CNA, stated that she walked R75 to and from the shower room and that he was not wearing his orthotic when walking with her. On 7/23/09, during an interview with E3, the Assistant Director of Nursing, she stated that the orthotic was fitted on 6/17/09 and that it arrived approximately on 6/25/09 which corresponded to a nurse's note, dated 6/25/09, that the orthotic was in place. However, there was no further documentation of use of the orthotic. On 7/23/09, E5 the Unit Manager, acknowledged that the facility failed to follow through after the orthotic arrived with proper use and a breaking in schedule supplied by the orthotic company. Additionally, on 7/23/09 E6, the Certified Occupational Therapy Aide, acknowledged that their department was not aware that the orthotic	F 311	F311 1. R75 was seen by the Occupational Therapist during the State Survey. R75 was placed on Restorative Nursing Services to perform lower extremity exercises with a #3 weight, blue theraband, to do sit to stand transfer training, and to ambulate 150-200 feet with single point cane and MAFO to left foot. 2. All residents who require an orthotic have the potential to be affected by the deficient practice. 3. Therapists will assess resident for orthotic needs. If orthosis is needed by the resident, therapist will obtain order from physician and then place order for orthotic device. Therapists will do this for all orthotic devices. Any orthotics ordered by an outside providing physician will be reported by the Unit Nurse Manager to therapy for further follow up and monitor. All resident orthotics, ordered and delivered, will go to Physical Therapy for assessment and plan of care/treatment. Any orthotics found delivered to the resident room, and not the therapy department, will be taken to the therapy department as soon as possible for further evaluation and treatment by therapists. Therapists will in-service nursing	10/1/09

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F 311	Continued From page 34 had arrived. On 7/24/09, E7, the Physical Therapy Area Manager, acknowledged that he was calling the company to have all orthotics delivered directly to the Physical Therapy (PT) Department so that they would be assessed for proper fit by both the company providing it and the facility PT Department. E7 also stated that R75's orthotic did not fit properly and the company would have to adjust it. The facility failed to provide appropriate services to maintain R75's abilities related to his left foot drop by failing to follow through when the orthotic for R75 was delivered in June. Findings were acknowledged by E5, E6, and E7 between 7/23/09 and 7/24/09.	F 311	staff when an orthotic device is ordered for a resident. 4. Corrective action will be monitored by the therapy department (Physical and/ or Occupational) for ordered orthotics follow up as appropriate for receipt by the facility.	10/1/09
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide necessary services for 1 sampled resident (R75) who required assistance with activities of daily living (ADLS). The facility failed to provide nail care for R75. Findings include: R75 was readmitted to the facility on 4/21/09 with diagnoses including Alzheimer's Disease, depression and cardiovascular disease. A significant change Minimum Data Set (MDS) Assessment, dated 4/28/09, coded R75's	F 312	F312 1. R75 was given nail care upon learning of deficiency by DON and Unit Nurse Manager. 2. All residents have the potential to be affected by the deficient practice. 3. A "Hygiene Technician" position has been created and will be fully implemented by September 15, 2009. One tech will be on the 7-3 shift and one tech will be on the 3-11 shift. The hygiene technician will be a C.N.A. responsible for showing and bathing activities, and nail care. On resident's scheduled shower day, Hygiene tech will clean and cut nails as appropriate. Unit Mangers will address with hygiene tech which residents should not have nails clipped related to disease process (i.e. diabetes).	

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F 312	Continued From page 35 personal hygiene as requiring extensive assistance with one person assist and coded bathing as requiring the physical help of one person. On 7/20/09 and 7/23/09, observations were made of R75 with fingernails that were long with dirt under them. The facility failed to provide nail care to R75, a resident who required assistance with ADLS. In an interview on 7/23/09, E3, the Assistant Director of Nursing (ADON), acknowledged that R75's nails were long and dirty. E3, the ADON, also stated that E23, a CNA, had provided nail care to R75 after it was brought to their attention by the surveyor.	F 312	4. Corrective action will be monitored by the DON/designee and Unit Nurse Manager. Hygiene tech will monitor nail care need on a biweekly basis. Hygiene tech will hand the Unit Nurse Manager an care report at the end of shift to indicate which residents received care and which residents refused care and if care is still needed. The Unit Nurse Manager will then follow up as indicated to assure that proper hygiene is given to the resident.	9/30/09
F 313 SS=D	483.25(b) VISION AND HEARING To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based upon interview and record review it was determined that the facility to follow up to provide vision appointments for 2 sampled residents (R75 and R90). Findings include: 1. On the significant change Minimum Data Set Assessment (MDS), dated 4/28/09, R75 had	F 313	F313 1. R75 has been rescheduled for cataract surgery 9/18/09. R90 has had an eye exam paid for by the facility. Results were orders for glaucoma treatment with a follow up appointment 10/20/09. 2. All residents have the potential to be affected by the deficient practice. 3. Social Service Director developed a Sensory Assessment tool and will conduct a vision/hearing/dental assessment of all residents within the first 5 days of admission/readmisison and quarterly and follow up on scheduled appointments, done by nursing. 4. Corrective action will be monitored at resident quarterly care conferences and QI.	

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F 313	Continued From page 36 diagnoses including cataracts and glaucoma. On 3/23/09, R75's physician wrote an order for a cataract surgery consult. When the initial appointment was cancelled in April 2009, the facility failed to reschedule the appointment. On 7/23/09, in an interview with E3, the Assistant Director of Nursing (ADON), she acknowledged that the facility failed to follow up to schedule the cataract surgery consult. 2. Resident R90 had Minimum Data Set Assessments (MDS) dated 5/20/2008 and 2/15/2008 indicating that this resident's vision was highly impaired. A subsequent MDS assessment dated 5/23/2009 indicated that the resident's vision continued to be impaired. A social services note dated 3/23/2009 indicated that a vision appointment was to be made with the optometrist but, there was a need to obtain hospice approval for payment. On 7/23/2009, in an interview with E9, the Social Services Director, she acknowledged that the facility failed to follow up with hospice to inquire if they would pay for the optometrist so an appointment could be scheduled.	F 313		9/15/09
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	F318 1. R91 was assessed by Occupational therapist during State Survey visit and trialed for ROM and splinting. Resident was given an treatment plan and placed on Restorative Nursing for ROM and splinting. 2. All residents have the potential to be affected by this deficient practice.	

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F 318	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based upon interview, observation and record review it was determined that the facility failed to ensure that one resident (R91) with a limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Findings include: Resident R91 was observed as having limited range of motion of the digits on his left hand. Resident interview and record review revealed that resident R91 had a stroke in December 2008 which effected the left side functioning of his left arm and hand. While the rehabilitation assessment, dated 1/1/2009, addressed resident R91's ambulation and left arm range of motion, the facility failed to address range of motion of the digits on his left hand. The facility failed to assess, care plan and ensure that resident R91 received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion of his hand.	F 318	3. Occupational therapist will assess ROM on all residents scheduled for an MDS by RNAC. Occupational therapist will code section G3 and determine need for plan of care for ROM, either through further skilled therapies or Restorative nursing. Occupational therapy will determine need for splints and orthotics. 4. Corrective action will be monitored by RNAC through coding of ROM on MDS assessment (G3) and review of care plans at resident quarterly care conference. ROM plan of care and treatment will be monitored by Occupational therapist and Restorative Nurse through therapy referrals weekly and monthly by RNAC through generation of Functional Care Summaries. Weekly Restorative Nursing meetings will be reviewed at Quarterly QA.	
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

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F 323	Continued From page 38 Based on record review, observation and interview, it was determined that the facility failed to ensure that 1 sampled resident (R63) remained free from accident hazards. R63 had diagnoses including end stage dementia and a mood disorder with behaviors, including repetitive arm movements and resistance to care. It was known to the facility that R63 had a history of hitting the side rails on the bed and removing the bolsters (long, narrow cushion in place to pad the side rails). R63 sustained a finger fracture on or about 4/23/09 and an x-ray revealed "acute osteoporosis" of the finger, yet full side rails and bolsters remained in place. The rails, ordered for safety and as enablers had not been utilized by R63 as enablers for a long time due to deterioration of her dementia. Facility assessments on 3/3/09 and 6/2/09 confirmed that R63 did not have a medical condition that required side rails nor were they indicated or served as enablers to promote independence. The facility also failed to have PT/OT screenings/evaluations for appropriate use of the side rails/alternative devices. The facility failed to recognize that the side rails had become an accident hazard for R63, yet they remained in place. The facility also failed to have side rail care plan interventions that were current to R63's present situation. Additionally, there were electric wheelchairs being charged incorrectly in the hallways which posed an accident hazard. Findings include: Cross refer F221, example #1 1. R63 was admitted to the facility in 2004. Diagnoses for R63 included end stage dementia with a mood disorder, CVA (stroke) and blindness.	F 323	F323 1. DON and Unit Nurse Manager both spoke with the responsible party (daughter) for R63 and determined risks vs. benefits of side rail use. Daughter requested continuation of side rails use for use as an enabler for turning and repositioning and to increase resident's sense of safety and security. Resident holds onto the side rail during incontinency changes. Unit Nurse Manager obtained signed consent for side rail use, and obtained physician order for side rail use. RNAC updated care plan to reflect side rail use as an enabler for turning and repositioning and to increase resident's sense of safety and security at the request of the resident's daughter/responsible party. 2. All residents have the potential to be affected by the deficient practice. 3. ADON and Unit Nurse Managers are conducting facility wide assessment of all residents to determine risk versus benefits of side rail use in individual residents and assuring all appropriate consents and orders are in place on residents' charts. Electric wheelchairs will be stored/charged in back hall storage rooms on each nursing unit floor (2nd and 3rd floors). Administrator had storage rooms modified to accommodate electric wheelchair storage and charging	10/15/09

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F 323	Continued From page 39 An annual MDS (minimum data set) assessment, dated 2/28/09, and quarterly MDS, dated 5/29/09, stated that R63 had severe cognitive impairment with short and long-term memory impairment. R63 was totally dependent on staff for all care, bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed) required 2+ persons for physical assistance, and she required a mechanical lift with 2 persons for transfers. Review of R63's care plan for side rails, dated 3/2/09 and last updated 7/16/09, stated, "1. Resident has requested to use a side rail... 2 1/2 rails... for bed mobility/an enabler to promote independence and actively participate in his/her own care...". Approaches included, "1. Patient will fill out and sign Side Rail Consent Form... 3. Continued patient education on the safe use of side rails and encouraging use of alternative devices... 6. P.T. (physical therapy)/ O.T. (occupational therapy) screen/eval (evaluation) for appropriate use of side rails/alternative devices...". On 7/16/09, the facility added "Padded SRs (side rails) for safety, resident hits the SRs when agitated." R63's high risk for falls care plan, dated 7/24/08, last updated on 7/16/09, listed the approach, "... 26. padded SRs for protection... hits SRs...". On 4/24/09, a care plan was developed for R63 for "... is experiencing/has potential for pain secondary to osteoporosis has pathologic fx (fracture) R (right) hand 5th metatarsal (pinky finger) Resident at risk for further fx's secondary to combativeness." Approaches included, "... 12. padded SRs in bed". Review of a facility incident report and	F 323	by adding additional electrical wiring 9/22/09. DON will update and amend "Team Leader's Report" to include monitoring of electric wheelchair proper storage and charging on nursing unit floors' storage rooms. 4. Corrective action will be monitored by Unit Nurse Manager at resident quarterly care conference and documentation updated accordingly based on resident need and risk versus benefits. C.N.A. team leaders will monitor for proper storage and charging of residents' electric wheelchairs via use of "Team Leaders Report".	

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F 323	Continued From page 40 investigation, dated 4/24/09, stated that the resident's daughter came to staff at 8 PM and told them R63's right pinky finger was swollen and painful to touch. An x-ray, dated 4/23/09, stated, "... fracture... 5th proximal phalangeal base with mild displacement. There is associated soft tissue swelling. Impression: Acute osteoporosis (thinning of the bone with increased risk for fx) related right 5th finger fracture as described." A physician progress note, dated 4/30/09, stated, "... R 5th finger fx due to severe osteoporosis- no trauma/fall reported reported in Nursing Home...". Review of the clinical record, including the care plan, revealed no recent falls or fx's. MDS assessments from 8/30/08 through 8/28/09 revealed lack of diagnoses of osteoporosis or pathological bone fx's and falls or other fx's. An exception to this was a quarterly MDS assessment, dated 5/29/09, which incorrectly stated that R63 had "other fracture in last 180 days". R63's pain/osteoporosis care plan, developed on 4/24/09, stated that R63's finger fx was a pathologic fx, although subsequent quarterly MDS assessments, dated 5/29/09 and 8/28/09, failed to list a diagnosis of pathological fx. During an interview with E4 (unit manager) on 7/23/09, she stated that when she began employment in the facility in 1/09, she found sheets wrapped around R63's SRs. She believed that R63's daughter did it to protect the residents arms. E4 stated that she implemented the bolsters at this time, although the care plan reflected it was done later. E4 previously stated in an interview on 7/21/09 that R63's finger fx occurred after flailing her hand against the	F 323		

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F 323	Continued From page 41 padded side rail. On 7/23/09, E4 clarified that it was assumed that R63 hit her finger on the bolster. On 7/23/09, E17 (Certified Nurses Aide assigned to R63) was interviewed. She confirmed that the bolsters were initiated in 1/09 and stated that prior to that, she wrapped towels around the SR's because R63 was combative and hit the rails. E17 further stated that although the bolsters are attached by 4 velcro straps each, R63 could remove them and E17 had found them on the floor. E17 stated that staff put the bolsters back and she confirmed that R63 continued to hit her hands/arms on the side rails. Multiple observations from 7/20/09 to 7/24/09 revealed R63 lying on her back in bed with full bilateral SR's up and bolsters in place. R63 was not observed attempting to reposition herself or using the side rails as enablers. She did not appear to be aware of the rails. According to R63's ADL (activities of daily living) care plan, dated 7/24/08 and last updated on 3/2/09, an intervention, dated 9/5/08, stated, "Family requests resident be back in bed by 1600 (4 PM) if up early. Up approx. 2-3 hours daily." R63 spends approximately 21-22 hours per day in bed. During a family interview on 7/23/09, R63's POA stated that the family requested the side rails a few years ago, but R63 had not been able to use them as enablers for a "long time." The POA stated she never signed a consent for the rails. Facility assessments on 3/3/09 and 6/2/09 revealed that R63 did not have a history of falls, she did not have a medical condition that required	F 323		

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F 323	Continued From page 42 side rails, nor were they indicated or served as enablers to promote independence. Record review revealed lack of a signed consent for the side rails and lack of any PT or OT assessments or evaluations regarding the appropriate use of side rails/alternative devices as per the care plan. These findings were confirmed during interviews with E2 (Director of Nursing) on 7/22/09 and 7/23/09. R63 had a history of hitting the side rails when agitated, repetitive arm movements, resistance to care, and removing the bolsters placed on the inside of the bed in front of the side rails. The facility assessed in 3/09 and 6/09 that the side rails were no longer indicated and they no longer served as enablers to promote R63's independence. The facility failed to have a signed consent for usage of the side rails and they failed to have PT/OT screenings and/or evaluations to determine the appropriateness of the rails/alternative devices. R63 sustained a finger fx on or about 4/23/09, which was thought to be caused by R63 hitting the bolster and/or side rail. The facility care planned R63 to be at risk for further fx's due to combativeness, yet they failed to recognize her side rails as an accident hazard and thus, they remained in place as of 7/24/09. 2. Resident electric wheel chairs were observed being charged in the hallways on both the second and third floors. Electric Wheel chairs must be charged in a safe area approved by the fire marshal.	F 323		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident -	F 325		

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F 325	Continued From page 43 (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, interviews and observations it was determined that the facility failed to identify a severe weight loss for one resident (R 84) out of 37 stage II sampled residents. While the dietician documented weight loss R 84, who was at risk for weight loss, the facility failed to document that the resident sustained a 7.8 % weight loss in 3 months. The facility failed to follow the care plan for a resident at high risk for weight loss and failed to monitor the resident regarding the consumption of snacks and failed to ensure the resident consistently received the snacks as ordered. The care plan also failed to address the relationship between one of the resident's medical conditions Chronic Obstructive Pulmonary Disease(COPD) and his caloric needs. R 84 was admitted on 2/17/2009 with diagnosis which included hypertension, schizophrenia, emphysema and cancer. On the 7/20/2009 the physician's history and physical included the diagnosis of brain aneurysm, anxiety and pain. Review of the Minimum Data Set (MDS) for R 84 revealed 4 periods of discharge and reentry to the facility. The discharge dates were 4/15/2009,	F 325	F325 1. Resident #84 will have supplements documented on MAR as well as sandwiches. Preferences were updated. Resident will have weights checked weekly by RD and discussed at weekly high risk meeting. Resident visited weekly by Food Service Director to ensure that he is receiving the correct food items. 2. All residents that are readmitted, will be reviewed by the dietician to check on discharge and readmit weights. MD will be notified if weight change is 5 pounds or greater. These residents will then be reviewed at the high risk meeting. MAR's will be checked for supplement or snack orders that need documentation on MAR by the dietician. 3. The Dietician will assess/reassess each admission/readmission in a timely manner. The Dietician will be sure that all ordered supplements have been ordered and documented appropriately. The Dietician will also make proper recommendations for supplements/snacks. 4. Staff will review all High Risk readmissions at the weekly Nutrition Risk Meeting. The committee will review the checklist for each readmission and the MAR will be reviewed for accuracy.	10/15/09

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

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F 325	Continued From page 44 5/26/2009, 6/18/2009 and 7/12/2009. There was also a significant change MDS completed on 6/4/2009. The facility developed a care plan for alteration in nutrition and hydration dated 2/20/2009 and revised on 6/28/2009 and 7/24/2009. This included a goal of no significant weight loss through next review, and weight to remain above 145 pounds. The approaches included supplements as ordered, med pass 4 ounce three times a day, preferences obtained, sandwiches as ordered and document on MAR. Under evaluation the dietician wrote on 7/24/2009 weight at 129 pounds, will monitor at high risk. While the care plan identified periods when the resident lost weight it failed to identify the 7.8% weight loss in 3 months. Additionally the complete care plan failed to mention or identify the resident's diagnosis of COPD and how that would impact on R84's caloric requirements. Review of R 84 weights revealed the following: 2/24/2009 =159 pounds 4/27/2009=140 pounds 5/5/2009 =140 pounds 5/13/2009=139 pounds 5/20/2009=138 pounds 6/28/2009=132.6 pounds 7/22/2009=129 pounds 7/23/2009=129 pounds, which represents a 7.8% severe weight loss in a 3 month period. Review of the nutrition progress notes dated 6/28/2009 stated resident's oral intake had resumed to above 75%. Resource (supplement) needs to resume at 120 cc four times a day. At this time the resident requested 2 sandwiches	F 325		

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F 325	Continued From page 45 and 2 sodas everyday for a bedtime snack. A diet requisition was completed requesting this bedtime snack to be nightly and routine. Additionally a physician's order dated 6/28/2009 stated resume resource 120 ml 3 times a day and 2 Ham and cheese sandwiches and 2 sodas daily for HS snack. The physician order sheet for 7/09 also stated 2 Ham & Cheese sandwiches & 2 sodas every night. The admission nursing assessment dated 7/18/2009 stated the resident's weight as 130 pounds. The next dietary progress notes stated the following: 7/20/2009 resident visited and will assess on Tuesday(7/21/2009). 7/21/2009 sent to ER on 3-11. Resident had pains in stomach. will re-eval upon his return. 7/24/2009 see nutrition assessment for readmit note. The 7/24/2009 nutrition assessment identified R 84's weight as now at 129 pounds. The dietician resumed sandwiches as a snack and after discussion with the surveyor and wrote that the sandwiches would be added to the MAR and to more closely monitor intake. R84 lost 19 pounds as of 4/27/2009 and continued to lose a total of 26 pounds by 6/26/2009. Interview with facility staff (E2) revealed orders are not obtained for supplements and snacks until after an assessment by E8. Therefore a resident at risk for weight loss could possibly not receive snacks and or supplements until seen by the part time dietician on her next visit to the facility.	F 325		

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F 325	Continued From page 46 The facility policy entitled Nutritional Care Planning Process # 9 stated Those who fall within significant weight loss range are reported to the physician, dietary, RNAC, nursing administration and administration for interventions within 24 to 48 hours. Another facility policy entitled Snacks (between meal and bedtime) Serving stated in #2 Check tray before serving snack to be sure that it is the correct diet ordered... Review of the weight documentation on 7/22/2009 revealed that R 84's weight had dropped to 129 pounds from 132.6 pounds on 6/28/2009. Weight documentation again checked on 7/23/2009 by the surveyor and no weight had been done. During an interview with E 29 (CNA responsible for weights) on 7/23/2009 he was asked when he would do a reweigh and he said today. CNA returned at 3:15 PM and stated R 84's reweigh was 129 pounds. Interview with E5 (unit manager) at 1:50 PM on 7/23/2009 also confirmed that resource was not not reordered or resumed after 6/28/2009. R 84 returned on a weekend and resource was not recorded. Interview with E5 on 7/24/2009 at 9:45 AM revealed she was not aware of the reweigh at 129. Therefore the RD (E 30) and the MD were not notified. Interview with the medication nurse (E 30) at 10:30 AM on 07/23/2009 confirmed the supplement was not on the MAR and the resident is not currently receiving same. MD orders of 7/18/09 listed a sandwich snack. 7/24/2009 @10:15 AM Interview with E5 confirmed that she did not notify the MD or the	F 325		

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F 325	Continued From page 47 RD of decrease in weight 7/24/2009 10:30 AM interview with (the med nurse) E 30 confirmed that since 7/18/2009 the snack of 2 sandwiches was not on the MAR therefore the facility was unable to monitor the resident's consumption. During an interview with the with RD (E 8) she stated that the weight loss was due to the resident being hospitalized. She was not aware that the snacks were not on the MAR, she plans to reorder the supplement and the snacks will be put on the MAR. Observation of R 84 revealed the resident in bed at 8:03 PM on 7/23/2009. R 84 had received one not 2 sandwiches and a bag of chips and 2 sodas During an interview with the resident he stated he only received one sandwich. Apparently the tray was not checked prior to it being served to the resident for contents. R84 said I guess it is good that I at least get one. He ate the chips and the sandwich. The facility failed to identify a severe weight loss for R 84 by documenting when the resident sustained a 7.8 % weight loss in 3 months, failed to follow the care plan for a resident at high risk for weight loss and failed to monitor the resident regarding the consumption of snacks and supplements.	F 325		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329		

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F 329	Continued From page 48 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to have 2 (R63 and R91) sampled residents' drug regimens free from unnecessary drugs. The facility failed to monitor for behaviors and side effects related to the antipsychotic medication Seroquel and the antianxiety medication Ativan for R63. Additionally, the facility failed to list and document lesser alternatives (non-drug interventions) before administering Ativan and they to failed to perform an AIMS (Abnormal Involuntary Movement Scale) test when R63 was started on Seroquel. The facility failed to document an appropriate diagnosis for R91's Prilosec (for heartburn); the medication was subsequently discontinued. Findings include: 1. Diagnoses for R63 included end stage	F 329	F329 1. R63 and R61's care plans were amended for psychotropic use. R91: MD wrote physician's order for pharmacy indicating diagnosis for medication. 2. All residents have the potential to be affected by the deficient practice. 3. Care plans will be amended as needed. Behavior sheets were obtained and placed on the MAR's. Additional corrective action includes the MD being responsible for assuring that all resident medications have an appropriate diagnosis. The admitting MD will review residents' POS each month to ensure all resident medications have appropriate corresponding diagnosis. The MD will write in appropriate diagnosis for any medication found to not have an appropriate corresponding diagnosis. DON will obtain a weekly psychotropic report from pharmacy to update onto care plans by RNAC 4. New Monthly POS will be stored in a POS binder until reviewed by the admitting MD. Each admitting MD will review and monitor the POS binder for resident medications and appropriate corresponding diagnosis.	10/1/09

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F 329	Continued From page 49 dementia with a mood disorder and blindness. The 7/09 POS (physician order sheet) revealed that R63 had Seroquel (antipsychotic) 25 mg twice a day and Ativan (antianxiety) 1 mg every 6 hours as needed for agitation/aggression that was ordered on 5/26/09. Care plans were developed on 6/1/09 for the potential for psychotropic drug-related side effects related to taking antipsychotic and anxiolytic (antianxiety) medications. Approaches listed on the care plan included, "1... monitor for effectiveness and side effects of medication.... 4. Monitor and document signs/symptoms of adverse effects as well as positive effects from the drug...". The anxiolytic care plan also listed the intervention "... Explore ways to eliminate anxiety with resident..." and R63's antipsychotic care plan listed the intervention "... AIMS testing as per facility protocol...". The facility failed to list and document specific side effects (including behaviors) related to the medications, they failed to identify how they were going to monitor for effectiveness and side effects of the medications. They failed to identify and document approaches in which to reduce anxiety for R63, and failed to list lesser, non-drug interventions to implement before administering Ativan to R63. Findings were confirmed with E4 (Unit Manager) and E22 (Medication Nurse) on 7/23/09. E4 stated that the only place behaviors were documented were on ADL flow sheets (completed by Certified Nurses Aides) and on the back of the Ativan medication administration record. Additionally, interviews with E2 (Director of Nursing) and E4 confirmed that the facility failed	F 329		

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F 329	Continued From page 50 to perform an AIMS (Abnormal Involuntary Movement Scale) test when Seroquel was started on 5/26/09. They stated it was facility practice (confirmed in review of the facility AIMS testing policy) to do it 6 months after an antipsychotic was started and every 6 months thereafter, although the policy stated, "Tardive dyskinesia (TD) is a syndrome characterized by abnormal involuntary movements of the patient's face, mouth, trunk, or limbs which affects 20%-30% of patients... in elderly patients... TD can develop after as little as one month...". The facility failed to have a baseline AIMS test when R63's Seroquel was started on 5/26/09 so that a comparison could be made 6 months later to monitor for any changes. 2. Review of R91's 7/09 POS (Physician's Order Sheet) revealed an order, dated 1/1/09, "Prilosec 20 mg - 1 by mouth twice daily before meals." Review of the clinical record lacked evidence of a diagnosis or an adequate indication for its use. During an interview, E4, the unit manager, confirmed this finding after obtaining a physician's order, dated 7/23/09 which stated, "D/C (Discontinue) Prilosec OTC (Over The Counter)."	F 329		
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations and resident interviews it was determined that the facility failed to serve food that was palatable and served at an	F 364		

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F 364	Continued From page 51 acceptable temperature. Six residents (R13, R41, R27, R36, R66 and R39) complained about the food and test trays confirmed that the food was not palatable. Findings include: 1. During resident interviews on 7/20/09 and 7/21/09, R13, R41, R27, R36, R66 and R39 stated that the food was not good and not always served at the proper temperatures. 2. On 7/23/09, trays for dinner arrived on the 2nd floor at 5:09 PM. At 5:28 PM when the last tray was delivered, the test tray for R13 was evaluated for temperature and palatability. Temperatures on R13's tray included lasagna with marinara 124.5 degrees F, apple juice 71 degrees F, and milk 60.8 degrees F. The surveyor tasted the lasagna which was lukewarm, the green beans were cool, and the apple juice and milk were warm. The food was determined to be unpalatable. 3. On 7/23/09, trays for dinner arrived on the 3rd floor at 5:20 PM. At 5:42 PM when the last tray was delivered to a resident's room, the test tray for R41 was then evaluated for temperature and palatability. Temperatures on R41's tray included soup of the day 129 degrees F, lasagna with marinara 122.7 degrees F, green beans 114 degrees F, fruit cocktail 69.8 degrees F, cranberry juice 73.2 degrees F, and water for hot tea 128.9 degrees F. Two surveyors tasted the soup and the lasagna which were lukewarm, the green beans were mushy and cool, and the cranberry juice and tea water were warm. The food was determined to be unpalatable. 4. On 7/23/09, at 6:05 PM R39 was seated in a chair with her dinner tray on the bedside table in front of her. R39 stated that the food was "terrible" and consumed less than 25% of her	F 364	F364 1. Food Service Director will meet with R13, R41, R27, R36, R66, and R39 to determine any resident specific intervention. Dietary staff will be in-serviced by Food Service Director on food temperatures and palatability. 2. All residents have the potential to be affected by the deficient practices. 3. Weekly test trays will be completed by the FSD and RD. Staff will be in-serviced on safe food. Test tray results will be tracked weekly and posted in Operational Scorecard. 4. Corrective actions will be monitored by the Food Service Direction through Operational Scorecard which will include test trays, tray audits, resident satisfaction surveys, and pre-service temperature results. Food Service Director will present findings at facility Quarterly QA.	10/15/09

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F 364	Continued From page 52 meal. Additionally, on 7/20/09 an observation was made that the ice machine was not working in the kitchen. The facility failed to provide food that was palatable and at the proper temperature. On 7/24/09, findings were acknowledged by E12 Regional Dietary Manager, and E13 Food Service Director.	F 364		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews in the dietary area, it was determined that the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Findings include: 1. During the tour of the kitchen on 7/20/09 at 9:20 AM, a pan of frozen chicken (in two large bags) tabled for Wednesday lunch was observed being thawed at room temperature on a counter. Interview with E13, the dietary manager, confirmed that the frozen chicken should not have been thawing out at room temperature and it is	F 371	F371 1. Corrective action for improper sanitary conditions of food preparation will be an dietary/kitchen staff in-service through HACCP. Food had just been delivered and dietary staff were in the processes of being put away. Dented cans were removed and discarded. 2. All residents have the potential to be affected by the deficient practice. 3. Staff will be in-serviced by Food Service Director on sanitary conditions of food preparation to be completed by September 11, 2009. Food to be put away promptly and appropriately when delivered 4. Compliance will be tracked and monitored through monthly in-service logs to be maintained by the Food Service Director.	10/15/09

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F 371	Continued From page 53 facility policy to thaw frozen food products in the refrigerator. 2. During the tour of the kitchen on 7/20/09 at 9:20 AM, at least 3 large cans (kidney beans, ketchup, spinach) were observed dented at the crease in the food storage area.	F 371		
F 411 SS=D	483.55(a) DENTAL SERVICES - SNF The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that one sampled resident (R13) did not receive necessary dental services in a timely manner. Findings include: R13 was admitted to the facility on 3/6/09 with diagnoses that included weight loss. Observations of R13 throughout the survey from 7/20/09 through 7/24/09, revealed that he had some bottom teeth and no top teeth. Top dentures were observed on his bedside table.	F 411	F411 1. Social Service Director has contact R13's legal Financial POA and requested financial information to qualify resident for Nemours certification in order to obtain dental services including fitting and new dentures. Social Service Director is awaiting financial information, not yet received as of 9/1/09. Social Service Director will make a follow up phone call to remind the Financial POA of the need for financial information. 2. All residents have the potential to be affected by the deficient practice. 3. Social Service Director developed a Sensory Assessment to be done upon admission/readmission and quarterly thereafter to track vision, hearing, and dental needs and follow up on scheduled appointments, done by nursing. 4. Corrective action will be monitored at resident quarterly care conferences and QI.	9/30/09

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F 411	Continued From page 54 During an interview on 7/21/09 at 9:00 AM, R13 stated that his top dentures did not fit anymore and that he was unable to chew everything. Review of R13's clinical record revealed that the only oral assessment that he had was on 3/6/09 upon admission which stated that the resident had his own teeth on the bottom and upper dentures. Care plans for "Dental" and "ADL's" indicated the same. There was no evidence that staff were aware of R13's ill-fitting top dentures. An interview with E4, the unit manager, on 7/23/09, revealed that oral assessments were done upon admission and then again only if a CNA (Certified Nurse Aide) reported a problem. During an interview with E9, the facility's social worker, on 7/23/09, when asked how residents were identified as needing dental services, she stated that nursing reported the problem to her and she would arrange for dental care. She stated that all residents are provided with yearly dental care. Since R13 was only admitted four months ago, he would not be scheduled for dental services until he had been in the facility for close to one year, unless there was an immediate need for care. The facility failed to provide dental services for R13 which resulted in chewing problems. This resident had a history of weight loss, yet staff was unaware that he had ill-fitting top dentures and missing bottom teeth which made it difficult for him to eat all foods. Findings were acknowledged by facility administration at the informational meeting on 7/24/09.	F 411		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Regency Healthcare and Rehab Center

DATE SURVEY COMPLETED: July 25, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Revised state report after IDR of 9/30/09. An unannounced QIS annual survey was conducted at this facility from July 20, 2009 through July 25, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 98. The survey sample totaled 107 residents, which included 40 census residents, 30 admission residents and 37 stage 2 residents.	
3201	**Nursing Home Regulations For Skilled and Intermediate Care**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This requirement is not met as evidenced by:**	3201.6.1.1 What corrective action(s)will be taken to ensure compliance with 3201.6.1.1: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F311, F312, F313, F318, F323, F325, F329(1), F364, and F411.

Provider's Signature Title NHA Date 10/14/09

NAME OF FACILITY: Regency Healthcare and Rehab Center

DATE SURVEY COMPLETED: July 25, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross refer to CMS 2567-L, survey date completed 7/25/09, F311, F312, F313, F318, F323, F325, F329 (1), F364, and F411.	
3201.6.5	**Nursing Administration**	
3201. 6.5.6	**A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 7/25/09, F279	3201.6.5.6 What corrective action(s) will be taken to ensure compliance with 3201.6.5.6: • Cross refer to the CMS 2567-L survey report date completed 7/25/2009, F279.
3201. 6.5.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A**	3201.6.5.7 What corrective action(s) will be taken to ensure compliance with 3201.6.5.7: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F280.

NAME OF FACILITY: Regency Healthcare and Rehab Center

DATE SURVEY COMPLETED: July 25, 2009

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	complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment. **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey date completed 7/25/09, F280.	
3201. 6.5.8	**This requirement is not met as evidenced by:** **The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.** Cross refer to CMS 2567-L, survey dated completed 7/25/09, F221.	3201.6.5.8 What corrective action(s) will be taken to ensure compliance with 3201.6.5.8. • Cross refer to CMS 2567-L survey date completed 7/25/2009, F221.
3201.6.5.8.2	**The facility shall follow a comprehensive, systematic process of evaluation and care planning to ameliorate medical and psychosocial indicators prior to restraint use.** Cross refer to CMS 2567-L, survey dated completed 7/25/09, F221.	3201.6.5.8.2 What corrective action(s) will be taken to ensure compliance with 3201.6.5.8.2: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F221.

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3201.6.5.8.3	**The resident's care plan shall document the facility's use of interventions, such as modifying the resident's environment to increase safety, and use of assistive devices to enhance monitoring in order to avoid the use of restraints.** Cross refer to CMS 2567-L, survey dated completed 7/25/09, F221.	3201.6.5.8.3 What corrective action(s) will be taken to ensure compliance with 3201.6.5.8.3: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F221.
3201.6.5.8.6	**When the use of restraints has been implemented, the facility shall initiate a systematic process, on an ongoing basis, documented in the care plan, in an effort to employ the least restrictive restraint.** Cross refer to CMS 2567-L, survey dated completed 7/25/09, F221.	What corrective action(s) will be taken to ensure compliance with 3201.6.5.8.6: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F221.
3201.6.6	**Activities**	
3201.6.6.1	**The nursing facility's activities program shall provide diversified individual activity plans and group activities for each resident based on the comprehensive assessment as well as an activity assessment conducted by the activity director. The activities offered shall reflect the needs, interests, abilities, preferences, limitations and age of each resident.**	3201.6.6.1 What corrective action(s) will be taken to ensure compliance with 3201.6.6.1: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F248.

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	Cross refer to CMS 2567-L, survey dated completed 7/25/09, F248.	
3201.6.7	**Social Services**	
3201.6.7.1	**The facility shall identify each resident's need for social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident; and shall assist each resident to obtain all required services to meet the individual resident's needs. These social services shall include, but not be limited to:**	
3201.6.7.1.1	**Making arrangements for obtaining needed adaptive equipment, clothing and personal items.** Cross refer to CMS 2567-L, survey dated completed 7/25/09, F250.	3201.6.7.1.1 What corrective action(s) will be taken to ensure compliance with 3201.6.7.1.1: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F250.
3201.6.7.1.2	**Making referrals and obtaining services from outside entities.** Cross refer to CMS 2567-L, survey dated completed 7/25/09, F250.	3201.6.7.1.2 What corrective action(s) will be taken to ensure compliance with 3201.6.7.1.2: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F250.
[illegible].5	**Assisting residents to determine how they**	

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	would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions **This requirement is not as evidenced by:** Cross refer to CMS 2567-L, survey dated completed 7/25/09, F250.	3201.6.7.1.5 What corrective action(s) will be taken to ensure compliance with 3201.6.7.1.5: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F250.
3201.6.8	**Food Service**	
3201.6.8.3	**Nutritional Assessment**	
3201.6.8.3.3	**The facility shall have an ongoing evaluation and assessment program to meet the nutritional needs of all residents.** Cross refer to CMS 2567-L, survey dated completed 7/25/09, F325.	3201.6.8.3.3 What corrective action(s) will be taken to ensure compliance with 3201.6.8.3.3: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F325.
3201.6.11	**Medications**	
3201.6.11.1	**Medication Administration**	
3201.6.11.1.1	**All medications (prescription and over-the-counter) shall be administered to residents in accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented**	3201.6.11.1.1 What corrective action(s) will be taken to ensure compliance with 3201.6.11.1.1: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F329.

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	supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering physician or prescriber within 10 days. Cross refer to CMS 2567-L, survey dated completed 7/25/09, F329, example 2.	
3201.7.0	**Plant, Equipment and Physical Environment**	
3210.7.3	**Facility Systems Requirements**	
3201.7.3.3	**Facility lighting shall meet current standards of the Guidelines for Design and Construction of Health Care Facilities.** Cross refer to CMS 2567-L, survey dated completed 7/25/09, F256.	3201.7.3.3 What corrective action(s) will be taken to ensure compliance with 3201.7.3.3: • Cross refer to CMS 2567-L survey date completed 7/25/2009, F256.
3201.7.5	**Kitchen and Food Storage Areas**	
3201.7.5.1	**Facilities shall comply with the Delaware Food Code.** **This requirement is not met as evidenced by:** **Based on dietary observations on 3/23/2009, it was determined that the facility failed to comply with sections: 3-202.15 and 3-501.13 of**	3201.7.5.1 What corrective action(s) will be taken to ensure compliance with 3201.7.5.1: • (Ex 2) Cross refer to CMS 2567-L survey date completed 7/25/2009, F371.

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	the Delaware Food Code. Findings include: 3-202.15 Package Integrity.* Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. Cross refer to CMS 2567-L, survey date completed 7/25/09, F371, example 2. 3-501.13 Thawing. Except as specified in ¶ (D) of this section, potentially hazardous food shall be thawed: (A) Under refrigeration that maintains the food temperature at 5°C (41°F) or less, or (B) Completely submerged under running water: (1) At a temperature of 21°C (70°F) or below, (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and: (4) For a period of time that does not allow thawed portions of a raw animal food requiring	3201.7.5.1 What corrective action(s) will be taken to ensure compliance with 3201.7.5.1: • (Ex 1) Cross refer to CMS 2567-L survey date completed 7/25/2009, F371.

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	cooking as specified under ¶ 3-401.11 (A) or (B) to be above 5°C (41°F) as specified under ¶3-501.16 (C) for more than 4 hours including: (a) The time the food is exposed to the running water and the time needed for preparation for cooking, or (b) The time it takes under refrigeration to lower the food temperature to 5°C (41°F) as specified under ¶ 3-501.16 (C); (C) As part of a cooking process: Cross refer to CMS 2567-L, survey completed 7/25/09, F371 Example 1.	
16 Del. C., Subchapter II, § 1121	It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the patients and residents in sanitoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interests of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with	16 Del. C., Subchapter II, SS 1121 What corrective action(s) will be taken to ensure compliance with 16 Del. C., Subchapter II, SS 1121 • (Ex 1) Cross refer to CMS 2567-L survey date completed 7/25/2009, F241.

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	such rights, which shall include but not be limited to the following: (1) Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality. Cross refer to CMS 2567-L, survey completed 7/25/09, F241. (11) Every patient and resident may associate and communicate, including visits and visitation, privately and without restriction with persons and groups of the patient's or resident's own choice (on the patient's or resident's own or their initiative) at any reasonable hour; may send and shall receive mail promptly and unopened; shall have access at any reasonable hour to a telephone where the patient may speak privately; and shall have access to writing instruments, stationery and postage. Nothing in 77 Del. Laws, c. 49 shall preclude a nursing facility or similar facility, as defined in § 1102(4) of this title, from restricting visitations due to attempts	• (Ex 1) Cross refer to CMS 2567-L survey date completed 7/25/2009, F241.

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	to interfere with patient care, the presentation of a threat to staff, patients and residents, or personnel, or other actions disruptive to the facility's operations. This requirement is not met as evidenced by: Cross refer to CMS 2567-L, survey completed 7/25/09, F174. (25) Every patient and resident shall be free to make choices regarding activities, schedules, health care and other aspects of the patient's or resident's life that are significant to the patient or resident, as long as such choices are consistent with the patient's or resident's interests, assessments and plan of care and do not compromise the health or safety of the individual or other patients or residents within the facility. This requirement is not met as evidenced by: Cross refer to CMS 2567-L, survey completed 7/25/09, F242. (26) Every patient and resident has the right to participate in an ongoing program of activities designed to meet, in accordance with the	• (Ex 11) Cross refer to CMS 2567-L survey date completed 7/25/2009, F174. • (Ex 25) Cross refer to CMS 2567-L survey date completed 7/25/2009, F242.

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	patient's or resident's assessments and plan of care, the patient's or resident's interests and physical, mental and psychosocial well-being. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 7/25/09, F248. **(28) Every patient and resident shall receive notice before the resident's room or roommate is changed, except in emergencies. The facility shall endeavor to honor the room or roommate requests of the resident whenever possible.** **This requirement is not met as evidenced by:** Cross refer to CMS 2567-L, survey completed 7/25/09, F247.	• (Ex 26) Cross refer to CMS 2567-L survey date completed 7/25/2009, F248. • (Ex 28) Cross refer to CMS 2567-L survey date completed 7/25/2009, F247.